Better Value Workgroup

Wednesday, September 16th 2015 - 9:00 a.m. – 12 p.m.
Thomas Memorial Hospital Education Center – South Charleston, West Virginia

MEETING SUMMARY NOTES

Today's Expected Results:

- Strengthen working relationships among workgroup members
- Learn about other states that have implemented regional care coordination systems
- Provide recommendations for regional care coordination in West Virginia
- Provide feedback and recommendations regarding aligned quality measures
- Identify next steps, materials and expertise needed for our next session, unresolved issues regarding proposed regional care coordination and preparation for October's focus on Behavioral Health

Co-Chairs: Jeremiah Samples and Jeff Wiseman

Facilitator: Bruce Decker

Participants: 32 people – 23 in person and 9 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	The third SIM Better Value Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
Review of Workgroup Meeting Results to Date	Mr. Austin provided a PowerPoint presentation summarizing the results of all SIM workgroups to date. Five key themes for the SIM model design have emerged. These are as follows: 1. Must include care coordination / coordinators 2. Must be an integration of behavioral health and physical health 3. Must be alignment of provider and payor quality measures 4. Must include telehealth / telemedicine 5. HIT must be a backbone, aid to this model design and its deployment
West Virginia Tobacco Prevention Plan Proposal	A one-page handout of the tobacco section of the State Health Improvement Plan (SHIP) was shared with participants.
States that Have Implemented Regional Care Coordination Models - Presentation and Small Group Discussion	In setting the stage for small group discussion and feedback, Mr. Austin reviewed three states that are implementing regional care coordination approaches: Colorado, North Carolina and Minnesota. In small groups, participants discussed the following questions and provided feedback to the larger group. **The responses below have been lightly edited for clarity.** 1. What do you like most / least about any of the presented regional care coordination models? <u>Most Liked</u> • In West Virginia, we need more local control similar to Colorado • We like Minnesota's all-payor approach • We like Colorado's flexibility in design of regional models • We like Colorado's statewide analytics system • The models add and assure care coordination

	• Make care approaches more standard and simplifies processes for providers, lowering admin burden • Incremental approach – replicate many of the systems shown in many of the models <u>Least Liked</u> • North Carolina – care coordination uncertainty • Minnesota – all-payors involved creates a complex system • Colorado – provider participation lax; medical focused • Lacking health focus – to the extent we understand the models • Focus on health • Unclear how the models engage members • Missing proof that the models work, such as ROI and outcomes • These models could limit choices of providers 2. How does West Virginia ensure that regional care coordination models focus on a comprehensive health approach and not simply a medical approach? • We still need to define a health model • Care coordination is key to making this model work • We need the data to follow the patient, including behavioral health data • Need to focus on definitions in a health model, including defining care coordination populations served • Engage in proactive care coordination, not retroactive • Determine whether the approach is incremental or radical in nature and structure • Consider the social determinants of health to focus on each person's health. • Adopt a more holistic health model • Involve the community in the model

	3. Please answer the following: A regional care coordination model must _____. **Reminder: this is what the model SHOULD / MUST include.** • Integrate behavioral health into primary care • Have a local presence • Must have good data analytics • A payment system that is based on risk • Must integrate e-data and telehealth capability • Show, through measures or data, improved outcomes and have patient-centered focus and choices • Holistic approach • Provider coordination • Public participation • Coordinate care • Incentivize providers for improving / maintain quality and for engaging members • Accept risk at some point • Share administrative infrastructure / governance • Preventative care / services component • Full practice authority for nurses • Each region must provide the same quality of care – regional care consistencies / standardization. • Model has to better align incentives to ensure all levels (payors, providers, managed care, specialties, patients) are performing the required tasks to make the model sustainable over time • Need a clear obesity strategy—which has not been defined / identified and based more on behavioral strategies • Tailored to the belief system(s) in the different counties, and may need to have variations in the way the model is delivered

	4. Please answer the following: A regional care coordination model should not _____. **Reminder: this is what the model <u>SHOULD NOT</u> include.** • Have adverse selection / cherry picking of participants • Add administrative burdens, bureaucracy and additional layers to the current system • Be single payor • Have carve outs for various health care services • Be hospital controlled • Be payor controlled • Cause variations in care across regions • Be more costly than the current system
Quality Measures Alignment – Presentation and Small Group Discussion	In small groups, participants reviewed Medicaid Managed Care and Highmark Blue Cross Blue Shield quality measures. Considering both sets of measures, they then discussed the following questions and provided feedback to the larger group. **The responses below have been lightly edited for clarity.** 1. What quality measures would you add? • Population-based quality measures • Behavioral health – quality measures of those screened for depression, follow up after discharge, etc. • Burden on staff to record / report measures • Oral health / process measures • Behavioral and physical health coordination measure • Referring at risk-patients to evidence-based programs • Adult and child LCMS quality measures • More outcome measures • Reduced high blood pressure

	• BMI • Pediatric BMI • Tobacco cessation with necessary coding • Prenatal / post-partum care 2. What are the greatest benefits to having aligned quality measures? • Administrative simplification from provider reporting perspective • Potential to give consumers much better quality • Should garner better outcomes • Level playing field • Focus efforts on priority efforts • Would have consistent format in terms of the system and measures • Ease of use • Would help improve the health of West Virginia and at the same time contain costs—make sure the entire process is addressed—if standard measures are identified and aligned to allow the process to continue from payors back to the providers 3. What are the greatest risks to having aligned quality measures? • Getting consensus / agreeing to the same quality measures • Only focusing / doing what is measured and missing other important interventions • Could lead providers to cherry pick and not focus on holistic care • Ensure that we are measuring the right things • Ensure that measures are not too burdensome for providers • Limits innovation and flexibility • Need to strike a balance between payor budget priorities / different populations • Lack of established body / process to set common measurements

	• Identify poor performing areas of medical services – pinpoint areas that need improvement (benefit / risk) • Designing the system the correct way to properly align governmental bodies 4. How do we accomplish getting quality measures aligned across payers and providers? • Start small – agree on baseline measures • Look at what other states have done – California, for example • Engage provider community in selecting measures • Built these measures into model while being flexible as it evolves • Cannot lose sight of patient • Mandate vs. consensus: must be consensus • Ability to adjust for risk • Use evidence-based measures that are proven and have been established • Having provider input to ensure that measures are current and up-to-date **Other Points from Better Value Team Activity Notes** • What measures should be removed or standardized across payers to reduce provider burden? • What input do the providers have when quality measures are identified? • Having provider input would help to keep measures current and the most up-to-date as possible. • What are we trying to do with these measures (purpose of measures)?
Parking Lot	• Deputy Secretary Jeremiah Samples noted two additional themes - regional and holistic approach • Medical vs. Health (define it) • Define medical neighborhood vs. medical home and be consistent in terminology • Who is the plan for? Medicaid only, or other populations? • Technical assistance request from other states (i.e., Colorado, etc) – utilize webinars

	• Poll workgroups on regional care coordination models and ask questions to identified states of interest, then create a grid representing answers / responses from these states. Include Colorado in the process.
Final Comments, Next Steps, Action Items, Assignments and Check Out	• **For October, the Better Value Workgroup meeting time and agenda are still to be determined. The workgroup will be notified as soon as final arrangements are made.**

Group Checkout (Verbatim Responses)

What worked well today?	***What would you change for the next meeting?***
• Believe progress was made • Observed improved inter-group dynamics and exchanges • Like the group discussion and sharing of ideas • Questions to answer were very clear and generated a lot of discussion • Facility was good • Good dialogue • I always learn so much in the small group exercises • Keep mixing us up • Mixing up the groups • Allowed great communication with others • Morning time • Snacks • Best meeting to date • Good discussion and small group participation • Snacks rocked	• Was enough progress made? i.e., concern over timelines • Need to define "health" vs. "medical" models • Need more concise agreement on what model will work for WV • Lack of definitions of the things we were discussing, such as health care vs. medical care • Move from theory to action – give people take aways they can begin to work on • Need clear definitions that each work group uses (ex. care coordination) • Invite providers to the table • Define medical vs. health • Invite providers to the table • Define medical vs. health • Cordless mic • Definition workgroup? Sub-group • Poll all SIM groups on which 3 RCC models to examine close up (most in my group say no to Minnesota)

	• After ID 3 models, gather all questions from all work groups on RCCs in advance • Hold interactive presentations with 3 model reps • Finalize comparison matrix and disseminate

Suggested Ideas for Additional Workgroup Members

- None